No. 89-1150

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

BLUE CROSS AND BLUE SHIELD
OF MARYLAND, INC.,

Petitioner,

v.

ROBERT WEINER, SR., MARGARET WEINER, MARK WEINER,
AND ROBERT WEINER, SR. AS PERSONAL REPRESENTATIVE
OF THE ESTATE OF STEVEN WEINER,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
FOURTH DISTRICT COURT OF APPEALS OF FLORIDA

PETITION FOR A WRIT OF CERTIORARI TO THE FOURTH DISTRICT COURT OF APPEALS OF FLORIDA

SHALE D. STILLER
Counsel of Record
LEONARD E. COHEN
ALLAN P. HILLMAN
FRANK, BERNSTEIN, CONAWAY
& GOLDMAN
300 E. Lombard Street
Baltimore, Maryland 21202
(301) 625-3500
Attorneys for Petitioner

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The Daily Record Co., Baltimore, MD 21202

QUESTIONS PRESENTED FOR REVIEW

1. Did the Fourth District Court of Appeal of Florida err in its holding which permitted assertion of state court jurisdiction and which applied state law to a cause of action which, under the Employee Retirement Income Security Act of 1974 (ERISA), can only be heard in a federal court applying federal law?

2. Did the Fourth District Court of Appeal of Florida err in holding that a business, purchasing insurance through a trade association group insurance plan, with eligibility limited to employees of the member businesses, was not covered by the protections and limitations of ERISA, merely because the employer was a small family business and the covered employees were also family members?

LIST OF PARTIES

Pursuant to Rules 21.1(b) and 28.1, Petitioner states that the following parties appeared in the Supreme Court of Florida:

a) Blue Cross and Blue Shield of Maryland, Inc.[1]
b) Robert Weiner, Sr.;
c) Mark Weiner;
d) Margaret Weiner; and
e) Robert Weiner, Sr., as Personal Representative of the Estate of Steven Weiner.

[1]Pursuant to Rule 28.1, the corporate affiliates of Blue Cross and Blue Shield of Maryland, Inc. are listed in Appendix G.

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RELEVANT STATUTORY PROVISIONS

Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1132 and 1144 (1985).

§1132. *Civil Enforcement*

(a) *Persons empowered to bring a civil action*

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan,-or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

(e) *Jurisdiction*

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

. . . . .

§1144. *Other laws*

(a) *Supersedure; effective date.*

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) *Construction and Application*

. . . . .

(6)(A) Notwithstanding any other provision of this section —

> (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

. . . . .

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

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COURT OF APPEAL OF FLORIDA

PETITION FOR A WRIT OF CERTIORARI TO THE FOURTH DISTRICT COURT OF APPEAL OF FLORIDA

The Petitioner, Blue Cross and Blue Shield of Maryland, Inc., respectfully requests that this Court issue a Writ of Certiorari to review the decision of the Fourth District Court of Appeal of Florida in this case.

OPINIONS BELOW

The Opinion of the Fourth District Court of Appeal of Florida, dated April 26, 1989, is reported at 543 So.2d 794 (Fla. Dist. Ct. App. 1989) and is reproduced in Appendix A. The Order of that Court denying the Petition for Rehearing and Rehearing En Banc, dated June 19, 1989, is reproduced in Appendix B. The Order of a divided Supreme Court of Florida, denying the Petition for Review, is reproduced in Appendix F.[2]

JURISDICTIONAL STATEMENT

The Order of the Supreme Court of Florida denying review was entered on October 24, 1989. Thus, pursuant to Rule 20.2, Blue Cross and Blue Shield of Maryland, Inc.'s filing of the instant Petition at this time is proper. The jurisdiction of this Court is invoked under 28 U.S.C. §1257.

STATEMENT OF THE CASE

This case involves far more than an effort by an insurance company to set aside a multi-million dollar judgment (nearly all of which is comprised of punitive damages), which is invalid under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 *et seq.*, and which was rendered by a state court which had no subject matter jurisdiction.

In spite of the strongest Congressional mandate for exclusive federal regulation and jurisdiction, and unanimous decisions of this Court recognizing the complete preemptive effect of ERISA, displacing both state statutory and common law in the field, *Pilot Life Insurance Co. v. Dedeaux,* 481 U.S. 41 (1987) and *Metropolitan Life Insurance Co. v. Taylor,* 481 U.S. 58 (1987), the Florida Fourth District

[2]Copies of the Final Judgment, and the two Orders on Plaintiffs' Motions for Attorneys Fees, entered in this matter by the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida, are reproduced in Appendices C, D, and E respectively.

Court of Appeal wrongly exercised jurisdiction over Respondents' claims. The claims were governed by ERISA, and should have been heard only in a federal court and decided only within the framework of ERISA's Congressionally-mandated limited scheme of remedies.

If the decision is allowed to stand, it threatens to remove thousands of employee benefit plans from the protection of ERISA. The goal of ERISA was to encourage employers to expand existing plans and to create new plans, for the benefit of millions of workers, a significant percentage of whom are employed by small businesses. This decision sanctions the enormously expensive state tort punitive damage litigation, involving employee benefit plans, which ERISA expressly sought to avoid. By striking at the heart of what this Court has referred to as "ERISA's crowning achievement," *i.e.*, exclusive federal authority to regulate the field of employee benefit plans, *Pilot Life*, 481 U.S. at 46, the decision threatens the creation, financial viability and continued existence of these plans.

The decision below caused grave injustice to Petitioner, and has the potential to undermine the strong protections Congress provided to employee benefit plans in ERISA. The Florida Appellate Court's wrongful assertion of jurisdiction — both judicial and legislative — calls into play this Court's role as a final guarantor of federal rights in our federal system.

Petitioner, Blue Cross and Blue Shield of Maryland, Inc. ("BCBSM"), is a non-profit Maryland corporation in the business of providing health insurance. In 1980, Association Financial Services, Inc. ("AFSI"), a brokerage firm which administers health insurance benefits for national level trade associations, decided to create a group health insurance plan for the members of state service station dealers' associations that were affiliated with the Service Station Dealers of America ("SSDA"). BCBSM agreed to underwrite the plan.

Three contracts were executed naming the SSDA as the insured. The contracts created a "Group Plan" of health insurance. Enrollment was specifically limited to employees and dependents of employees of member companies of an SSDA affiliate. The Group Plan provided that participation (1) could only begin after BCBSM was notified that the applicant was an employee of a member company of an SSDA affiliate and (2) would be terminated on the last day of the month that a participant's employment status ended. The contracts required the SSDA affiliates to notify BCBSM each month of the changes in the status of employees.

The Group Plan contracts were assigned to AFSI which acquired the endorsement of the Allied Gasoline Retailers' Association of Florida ("AGRA"). AGRA, an association of employers, was the Florida affiliate of the SSDA. As a result, all of AGRA's members and their employees were eligible to enroll in the Group Plan, administered by AFSI on behalf of AGRA. Blue Cross and Blue Shield of Florida, Inc. ("BCBSF"), a non-profit Florida insurance company, serviced the Group Plan.

The Weiner Service Station ("Station") is located in Dania, Florida. Robert Weiner, Sr., Robert Weiner, Jr. and others work at the Station. Early in 1982, Robert Weiner, Sr. called AGRA's field representative, Al Jacobson, regarding the Group Plan. Jacobson met with Robert Weiner, Sr., explained the Group Plan to him, and gave him a benefit book. The benefit book stated that the coverage was only available to employees and their dependents and that when a participant's status as an employee ended, his insurance under the Group Plan ended. Since coverage was only available to employees of the Station if the Station was a member of AGRA, the Station joined AGRA and applied for insurance under the Group Plan. As a result, the "Station Plan" was formed.

Two applications were filled out for the Station's employees. Robert Weiner, Sr. applied for a "family policy,"

and his application listed him as an "employee" and showed "Weiner Service Station" as the "Name of Employer." Robert Weiner, Sr.'s family policy covered Robert Weiner, Sr. and his dependents, Margaret Weiner, Steven Weiner, and Mark Weiner. Robert Weiner, Jr. applied for an "individual policy," covering only himself, and his application also listed him as an employee and showed the "Weiner Service Station" as the "Name of Employer." Under the terms of the Group Plan, the Station was responsible for payment of premiums and the Station did pay the premiums for both Robert Weiner, Sr. and Robert Weiner, Jr.

In the Summer of 1982, Steven Weiner became seriously ill and was later diagnosed as having the Acquired Immune Deficiency Syndrome. Later that summer, Mark Weiner was involved in an accident and became a quadriplegic. Coverage for the Weiners was provided from the Summer of 1982 until August 8, 1983. On that date, BCBSM determined that Steven Weiner and Mark Weiner were no longer covered by the Group or Station Plans by reason of each having reached the age of nineteen, and the payment of benefits was discontinued.

In September 1983, Robert Weiner, Sr. filed suit against BCBSM and BCBSF in the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida (the "State Trial Court") alleging that they had improperly denied benefits to Robert Weiner, Sr. and consequently, breached their duty of good faith and fair dealing, breached their fiduciary duty, committed fraud, and violated a Florida statute.

In March 1984, BCBSM informed the Weiners that it would reinstate coverage and pay all back claims due. It has processed all claims and paid all contractual benefits due under the Group and Station Plans.

In December 1984, the original Complaint was amended and Margaret Weiner, Mark Weiner, and Robert Weiner, Sr., as Personal Representative of the Estate of Steven Weiner,

were added as plaintiffs. In December 1985, the Weiners filed a Second Amended Complaint. In that Complaint, the Weiners alleged that BCBSM and BCBSF had committed three common law torts - fraud, intentional infliction of mental distress, and negligence. They eliminated all claims for unpaid benefits. The Second Amended Complaint sought recovery of compensatory and punitive damages.

On September 25, 1986, a jury verdict was returned in favor of the Weiners. The jury found BCBSM liable for fraud, intentional infliction of mental distress, and negligence and returned a verdict against BCBSM for $500,000 compensatory damages and $5,000,000 punitive damages. The jury also found BCBSF liable for fraud and intentional infliction of mental distress and returned a verdict against BCBSF for $200,000 compensatory damages and $1,500,000 punitive damages. In addition, the State Trial Court awarded attorneys' fees to the Weiners against BCBSM and BCBSF jointly in the amount of $1,411,600 (based upon three times the lodestar rate calculation). BCBSM and BCBSF appealed to the Florida Fourth District Court of Appeal (the "State Appellate Court").

In April, 1987, after the jury verdict but before briefing on the appeal, this Court issued its opinions in *Pilot Life* and *Metropolitan Life*. Reversing decisions of two federal circuit courts, this Court held that a plan participant's state common law tort claims (*i.e.*, all of the claims at issue in the *Weiner* case) were preempted; indeed, they were completely displaced by ERISA. Under ERISA, the state court could not have tried the case, the remedies awarded by it (punitive damages and huge attorneys' fees) could not have been granted, and a jury trial could not have been had. (*See* Reasons for Granting the Writ.)

BCBSM and BCBSF raised the issue of lack of subject matter jurisdiction in their appeal. This was the first time this federal question was raised in the case. See this Court's Rule 21(h). In both its Initial Brief (at 17) and Reply Brief (at

14), BCBSM specifically requested the State Appellate Court to dismiss the case for lack of subject matter jurisdiction or, at a minimum, to remand the case for a full evidentiary hearing upon whether the insurance plans were covered by ERISA.[3]

On April 26, 1989, the State Appellate Court affirmed the State Trial Court's judgment and award as to BCBSM and reversed the State Trial Court's judgment and award as to BCBSF.

With respect to the newly-raised ERISA issue, the Court acknowledged that the material facts (partial though they were) were "disputed," but, in effect, granted summary judgment on appeal concerning that issue. (App. A at 9-10.) Its decision concerning the pivotal ERISA issue was astonishingly brief and equally deficient:

> [Blue Cross/Blue Shield of] Maryland's principal assertion on appeal is that there is a lack of jurisdiction over the subject matter because the plaintiffs' claim is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001-1461, ("ERISA"), and that state courts do not have concurrent jurisdiction. *See also Pilot Life Insurance Co. v. Dedeau* (*sic*), 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). However, we find that ERISA does not apply to this policy.

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[3]Since the issue of ERISA's applicability was not presented to the State Trial Court, the record upon that issue was incomplete.

In 1988, before the 1989 decision by the State Appellate Court, BCBSM filed suit in the United States District Court for the Southern District of Florida, asking that Court to declare that the State Trial Court judgment was void since the causes of action had been preempted by ERISA, and the matter was one exclusively within the jurisdiction of the federal courts. The United States District Court abstained, in an unreported decision. That decision was affirmed (upon different grounds of abstention) by the United States Court of Appeals for the Eleventh Circuit. 868 F.2d 1550 (11th Cir.), *cert. denied,* ____ U.S. ____ (October 10, 1989). The Eleventh Circuit decision also was rendered before the decision by the State Appellate Court.

> ERISA regulates employee benefit plans, including ones providing for medical and hospital care, if the plan is established or maintained by an employer or employee organization, or both. ERISA §4(a), 29 U.S.C. §1003(a). Here, the record does not support a conclusion that there was an employee plan. The record does not reveal any agreement between the service station dealers associations and Maryland or AFSI. The evidence, although disputed, reflects that the plaintiff here was a sole proprietor who simply purchased a group policy for his family. *See Xaros v. U.S. Fidelity and Guaranty Co.*, 820 F.2d 1176 (11th Cir. 1987); *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982); *Taggart Corp. v. Life and Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980). Here there was no plan, or even an informal agreement, established or maintained by an employer or an employee organization. Nor were any fiduciary responsibilities created by this insurance marketing scheme, which simply made group insurance available to members of the organization.

(App. A at 9-10.) BCBSM's Motion for Rehearing and Rehearing *En Banc* was denied. (App. B.) The Supreme Court of Florida then denied BCBSM's request for review. (App. F.)[4]

REASONS FOR GRANTING THE WRIT

A. Introduction

ERISA, enacted by Congress in 1974, is a complex and thorough law governing employee benefit plans. This Court has recognized that ERISA "comprehensively regulates,

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[4]In July, 1989, the Weiners sought to enforce their Florida judgment in Maryland, a judgment which (with interest) has now grown to over $9 million. BCBSM launched a collateral attack on that judgment, alleging lack of subject matter jurisdiction in the Florida Trial Court, relying upon the principles recited in *Kalb v. Feuerstein*, 308 U.S. 403 (1940) and *Restatement (Second) of Judgments*, §12 (1982); *see generally* 13A Wright, Miller & Cooper, *Federal Practice & Procedure*, §3536 at 539-40 (1984). The United States District Court for the District of Maryland now is considering whether to permit collateral attack, *i.e.*, if it will grant a hearing on the issue of whether there was an ERISA plan in this case.

among other things, employee welfare benefit plans", *Pilot Life,* 481 U.S. at 44, and has observed on several occasions that the provisions of ERISA "are deliberately expansive and designed to establish pension plan regulation as exclusively a federal concern." *Pilot Life,* 481 U.S. at 46 (*quoting Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 523 (1981)). In establishing ERISA's comprehensive scheme, Congress balanced ERISA's broad coverage with limited remedies, thus effectuating a trade-off between coverage and liability which must be enforced and protected by the federal courts. *Pilot Life,* 481 U.S. at 54.

To ensure that ERISA remained a matter of exclusively federal concern and that participants and beneficiaries would have ready access to the federal courts, Congress provided that in all ERISA cases except those brought under §1132(a)(1)(B) — suits to recover plan benefits (a section not applicable here) — the federal courts would have exclusive jurisdiction. 29 U.S.C. §1132(e)(1).

In order to make ERISA's remedies exclusive and nationally uniform, Congress also provided ERISA with a unique and extraordinary preemption provision. 29 U.S.C. §1144. In *Pilot Life,* a plan participant whose benefits had been terminated alleged several state common law torts, including breach of fiduciary duty and fraud, and sought to recover compensatory damages for mental and emotional distress and punitive damages. This Court held that the plan participant's state common law tort claims were completely preempted by ERISA.

This Court began by recognizing the two basic tenets of ERISA preemption: (1) ERISA preempts any state law that "relates to" an employee benefit plan and (2) the only exception to this rule is if the state law is one "which regulates insurance." 481 U.S. at 45. This Court held that under the "broad common-sense meaning" of the term "relates to," the participant's state common law torts alleging improper processing of claims under an employee

benefit plan related to the plan. *Id.* at 47. In addition, this Court held that common law torts are not laws specifically designed to regulate insurance. *Id.* at 50-51. This Court therefore held that state common law torts based on alleged improper processing of claims under an employee benefit plan "undoubtedly meet the criteria for preemption." *Id.* at 48.

On the same day that this Court decided *Pilot Life,* it also decided *Metropolitan Life,* going one step further by holding that not only does ERISA preempt state common law torts, it totally displaces them. This Court referred by analogy to its prior decisions regarding the preemptive effect of §301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. 185, which is so powerful that preemption — normally a defense — becomes self-acting and destroys any state law claim infringing on the federal statute. This Court held that because ERISA's preemption provision was modeled after §301, ERISA similarly displaces state common law tort remedies with the remedies provided for in §1132(a).

Preemption of this magnitude is a matter of subject matter jurisdiction; therefore, this Court has held that if a state law claim is preempted, the state court loses its jurisdiction over the matter. *Metropolitan Life,* 481 U.S. at 6667; *see also Int'l Longshoremen's Ass'n v. Davis,* 476 U.S. 380, 391-392 (1986). ERISA is remarkable in that it provides for both exclusive federal jurisdiction and complete preemption of state law claims. Even other statutes evidencing the strongest of federal interests do not provide for such comprehensive federal dominance of their fields, *e.g.,* the LMRA (preemption without exclusive jurisdiction) and the Sherman Act (exclusive jurisdiction without preemption).

As will be demonstrated below, the Weiners' state tort claims were preempted by ERISA and were within the exclusive jurisdiction of the federal courts. The State Appellate Court's decision is fatally flawed, as a matter of

law and fact. The vitally important policies which Congress sought to protect by making ERISA exclusively a matter of federal concern, to insure *consistent* regulation and *limited* remedies, *Pilot Life,* 481 U.S. at 46, are undermined by that decision.

B. This Court Should Grant Certiorari Because the Decision of the Court Below That There Was No ERISA Plan Is Inexplicable As a Matter of Law and Fact

Despite the existence of an issue which was never litigated, and a limited and "disputed" factual record, the State Appellate Court concluded that the policy at issue was not an ERISA-covered employee welfare benefit plan. 543 So.2d at 798. (App. A at 9-10.) The State Appellate Court based its decision on its conclusion that Robert Weiner, Sr. was a sole proprietor of a business who simply purchased a group insurance policy for his family. *Id.*

This incredible decision is wholly unsupported in law or fact. It is absolutely clear (even on the partial record before the State Appellate Court) that *both* the Group Plan and the Station Plan satisfy the ERISA definition of an "employee welfare benefit plan."

The State Appellate Court's finding stands in direct contradiction to the decision of the United States Court of Appeals for the Ninth Circuit in *Kanne v. Connecticut General Life Ins. Co.,* 867 F.2d 489 (9th Cir. 1988), *cert. denied,* ____ U.S. ____, 109 S. Ct. 3216 (1989). In Kanne, the Ninth Circuit unanimously held that an employer association-sponsored group insurance plan is an ERISA plan.

The facts in *Kanne* are virtually identical to those in *Weiner.* As in the present case, the plaintiff (as well as his dependents) was covered under a health insurance plan by virtue of his employment with the employer. As in the present case, the employer belonged to a trade association which offered a group insurance plan to participating

employers. As in the present case, the employer subscribed to the group plan in order to provide medical coverage to its employees and their dependents. Finally, as in the present case, the employer association arranged to have the defendant insurance company underwrite the group plan.

In finding the employer association plan to be an ERISA plan, the Ninth Circuit initially relied upon ERISA's broad definition of the term "employee benefit plan," 29 U.S.C. §1002(1). Section 1002(1) defines an employee welfare benefit plan as follows:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

Thus, the five statutory components of an employee welfare benefit plan are: (1) a plan, fund or program, (2) established or maintained, (3) by an employer or by an employee organization or both, (4) for the purpose of providing benefits, (5) to participants or their beneficiaries. *See Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986); *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982); *Wickman v. Northwestern National Life Insurance Co.*, 9 EBC 1482, 1484 (D. Mass. 1987).

The Group Plan offered by AGRA qualifies as an employee welfare benefit plan under the five-part test set out by the Eleventh Circuit in *Donovan*. First, the Group Plan is a "plan, fund, or program." As *Donovan* points out, to meet this first requirement, there must be intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits. 688 F.2d at 1372. The Group Plan contracts clearly demonstrate that health

insurance is the intended benefit and that the benefits are provided to the employees of AGRA members and their dependents. In addition, AGRA members finance the Group Plan and the Group Plan contracts set out a full and detailed procedure for the application and collection of benefits. Therefore, the Group Plan meets the first *Donovan* requirement.

The Group Plan also satisifies the second *Donovan* requirement. The *Donovan* court held that the determination of whether a plan has been "established or maintained" turns on whether "a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Id.* at 1373. The Group Plan contracts spell out each of these elements: health insurance is the intended benefit, employees of AGRA members and their dependents are the intended beneficiaries, payments by AGRA members finance the plan, and the Group Plan contracts set out the procedure for receiving benefits.

The third *Donovan* requirement is also satisfied by the Group Plan. An "employer" is defined by ERISA to include "a group or association of employers acting for an employer." 29 U.S.C. §1002(5). AGRA is an association of service station dealer-employers that acts for the benefit of its employer members. Thus, AGRA is an "employer."[5]

The fourth and fifth Donovan requirements are also satisfied. The Group Plan provides medical, surgical, and hospital care benefits, and the beneficiaries of the Group

[5]Respondents have argued below that the Group Plan was "established and maintained" by AFSI — an "entrepreneurial business" — rather than by AGRA. It is true that AFSI, a company in the business of arranging group insurance coverage for trade associations, obtained the agreement of BCBSM to underwrite group plans endorsed by state service station dealer associations who were affiliated with the Service Station Dealers of America. But it is undisputed that, until the individual state association *endorsed* the plan and offered it to its member companies, no state plan came into existence. Thus, for ERISA purposes, the state association "established and maintained" the Group Plan.

Plan are the employees of AGRA members and their dependents. Consequently, the Group Plan established by AGRA meets the fourth and fifth requirements and qualifies as an employee benefit plan.[6]

In addition to relying upon the ERISA definition of an "employee welfare benefit plan," the Ninth Circuit in *Kanne* also accorded great weight to Department of Labor Regulations. Those Regulations, 29 C.F.R. §2510.3-1(j) (1989), set forth four requirements that a group insurance program must meet in order to fall *outside* the definition of an ERISA employee welfare benefit plan.

The Ninth Circuit made clear that it is *not* necessary for the program to fail to satisfy *all* four requirements to be an ERISA plan. To the contrary, a finding that "*any one* [has not been met] would prevent the exclusion of the insurance plan from ERISA coverage." *Kanne*, 867 F.2d at 492 (emphasis added).

Of the four findings that must be made to exclude a group insurance program from ERISA, three concern the role of the "employer" vis-a-vis the program:

> (1) no contributions are made by an employer . . .;
>
> . . . .
>
> (3) the sole functions of the employer . . . with respect to the program are, *without endorsing the program*, to permit the insurer to publicize the program to employees, . . . to collect premiums through payroll deductions . . . and to remit them to the insurer; and
>
> (4) the employer . . . receives *no consideration* in the form of cash or otherwise in connection with the

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[6]Respondents have argued that the Group Plan did not comply with ERISA's administrative and reporting requirements. This is incorrect. In any event, failure to comply with these requirements does not prevent ERISA coverage of a plan if one, in fact, has been established. Nor does such failure evidence the lack of a plan in the first instance. *Donovan*, 688 F.2d at 1372; *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503 (9th Cir. 1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1985); *Adam v. Joy Mfg. Co.*, 651 F. Supp. 1301, 1306 (D.N.H. 1987).

> program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions . . . .

29 C.F.R. §2510.3-1(j) (1989) (emphasis added).

The strong involvement of both the Weiner Service Station and AGRA, in connection with the Group Plan, where both are "employers" under the ERISA definition, causes the Group Plan to fail at least *three* of the four stated criteria for a *non*-ERISA plan:

(1) The Group Plan contracts provide that the "*Company* shall pay" the premiums each month for each eligible employee. In fact, it is undisputed that the Weiner Station actually paid the premiums. Thus, "contributions are made by an employer."

(3) AGRA *endorsed* the Group Plan and had its representatives enroll participating employers and their employees. Thus, AGRA, an ERISA employer, did more than merely publicize the program and collect premiums.

(4) AGRA received a per capita administrative fee to compensate it for endorsing and marketing the plan. Thus, AGRA, an ERISA employer, received consideration beyond administrative fees for merely making payroll deductions.

Under the Ninth Circuit's holding in *Kanne,* therefore, there can be no doubt that the AGRA Group Plan is an ERISA plan[7].

That the State Appellate Court was flatly wrong in deciding otherwise is illustrated by the three cases the Court cited to support its conclusion. Two of these cases, *Xaros v. U.S. Fidelity and Guar. Co.,* 820 F.2d 1176 (11th Cir.

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[7] In *Lambert v. Pacific Mut. Life Ins. Co.,* 259 Cal. Rptr. 398 (Cal. Ct. App. 1989), a California state appellate court used a similar analysis to find that a group insurance plan offered by an employer association, under which participating employers provided medical coverage to employees, was an ERISA plan. As in *Kanne,* the facts before the court in *Lambert* virtually mirror the present case.

1987), and *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), are clearly inapposite here, while the third case, *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), supports BCBSM's position.

In *Xaros*, the Eleventh Circuit simply held that subcontractors and sureties, all nonsignatories to a collective bargaining agreement, are not employers under the ERISA definition. For that reason, there was no subject matter jurisdiction over a claim against the nonsignatories for a signatory's failure to make contributions to a multiemployer employee benefit plan. Obviously, that decision has no application to the facts here.

Taggert is similarly irrelevant, since that decision involved a multiple employer trust (commonly referred to as a "MET"), not an employer-association endorsed group plan. A MET is a trust formed solely for the purpose of selling group health insurance to employees of *unrelated* employers who do not belong to an employer association. A MET plan is not an ERISA plan—an employer association plan is.

This has been the position of the Department of Labor at least since the publication of its News Release of August 6, 1979, where it stated that "a multiple employer plan [ERISA plan] can be established only if the employers are *members of an organized group or association*," and that "a MET arrangement is not a plan under ERISA if *unrelated* employers have merely adopted identically worded agreements that are offered by an independent third party . . . ." Department of Labor News Release No. 553, 5 *Pens. Plan Guide* (CCH) 22,194 (Aug. 10, 1979). (emphasis added).

The State Appellate Court's complete confusion over the ERISA issue is illustrated further by its reliance on *Donovan*. *Donovan* involved a MET which everyone agreed was not an ERISA plan because subscribers included unrelated employers and unions. Nonetheless, the Eleventh Circuit, in a unanimous *en banc* decision, concluded that

many of the employers and unions that subscribed to the MET in order to provide health insurance for employees or members established *their own* individual employee welfare benefit plans that were subject to ERISA.

Thus, contrary to the State Appellate Court, not only is the AGRA Group Plan an ERISA plan, the Station Plan *also* qualifies as an individual "employee welfare benefit plan," *i.e.*, an ERISA plan. An employee welfare benefit plan may be created without a formal, written plan. *Donovan*, 688 F.2d at 1372; *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1504 (9th Cir. 1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1984); *Wickman v. Northwestern National Life Insurance Co.*, 9 EBC 1482 (D. Mass. 1987). In addition, Department of Labor Regulations establish that an employer needs only one common law employee to qualify as an "employer" under ERISA. 29 C.F.R. 2510.3-3 (1989). The Station was an employer, since at least Robert Weiner, Sr. and Robert Weiner, Jr. were employed at the Station, and both Robert Weiner, Sr. and Robert Weiner, Jr. applied for insurance under the Group Plan as employees of the Station. By joining the Group Plan, the Station provided its employees and their dependents with the opportunity to receive health insurance and formed an ERISA-covered employee welfare benefit plan.[8]

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[8]The State Appellate Court found that Robert Weiner, Sr. ran the Station as a sole proprietor, and that his purpose in purchasing insurance was to provide coverage for his family. This is a *non sequitur*; family protection is a goal of most ERISA plan participants. More importantly, it is *undisputed* that one son was covered only because of his employee status. Finally, it would be irrelevant legally, but also disingenuous to argue that, while that son worked for the Station, no insurance was purchased for any other "employees." In his deposition taken in the case, on April 25, 1986, Robert Weiner, Sr. testified that he had no employees besides his son, and that the other individuals who worked at the station (including an attendant who pumped gas) were "independent contractors." Assuming *arguendo* that Mr. Weiner was truthful, it is obvious that reliance on the fact that no insurance was purchased for any other employees to support an argument that the Group Plan was not an ERISA plan is specious, since there *were* no other employees. In any event, it is

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In addition to its unremarkable finding that the MET before it was not an ERISA plan, the Fifth Circuit in the *Taggart* case also held that the Taggart Corporation, by subscribing to the MET, had *not* established an individual employee welfare plan that was covered under ERISA. As discussed above, the Eleventh Circuit in *Donovan* severely limited this second *Taggert* holding. 688 F.2d at 1375; *See also Wickman,* 9 EBC at 1488.

In any case, *this second Taggart holding is no longer the law.* The remarks of Congressman Erlenborn, a co-sponsor of the 1983 amendment to ERISA (part of the Miscellaneous Tax and ERISA Provisions, Pub. L. No. 97-463, 96 Stat. 2605), demonstrate that Congress was so troubled by the second *Taggart* holding that it expressly overruled the holding when it amended ERISA in 1983 to add, *inter alia,* §1144(b)(6)(C). He stated:

> Another provision (new ERISA section 514(b)(6)(C)) clarifies present law and deals with a question which has arisen as to whether ERISA applies to any aspect of a multiple employer welfare arrangement which does not meet the ERISA welfare plan definition (hereinafter referred to as a MET).
>
> Since employers frequently subscribe to these MET arrangements to provide employees with welfare benefits, there is a strong presumption that ERISA applies. The Department of Labor, which has taken the position that the MET itself does not constitute a single umbrella-like employee benefit plan, has consistently maintained that *each employer or union which subscribes to the MET has established its own employee benefit plan.* Under this analysis, the MET is not a single large plan, but rather a funding vehicle for a number of small individual employee benefit plans.
>
> *The Department of Labor's analysis is entirely consistent with the congressional intent under ERISA.*

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undisputed that "employee status" was required for eligibility under the Group Plan, and that Robert Sr. and Robert Jr. could only be eligible because of their employee status — not because of their familial ties. That alone is dispositive of the State Appellate Court's "family" coverage distinction. (App. A at 9-10.)

> Nevertheless, the Court of Appeals for the Fifth Circuit, in *Taggart Corp. v. Life & Health Benefits Administration,* 617 F.2d 1208 (5th Cir. 1980), has held that ERISA does not apply to the plans which subscribe to the MET. Even more disturbing is the reasoning of this decision which holds that employers which purchase insurance to underwrite benefits and/or which hire third parties to administer the plans do not establish welfare plans covered by ERISA. *This reasoning is wholly inconsistent with the language of ERISA, its legislative history, the case law and the shared understanding of the employee benefit plan community. It is also a critical issue because it affects the jurisdictional scope of ERISA.*
>
> While there is every reason to believe that the courts will readily see the error of the Taggart decision (e.g., the Court of Appeals for the 11th Circuit has in an en banc hearing ruled that ERISA applies to the "plans" that subscribe to a MET) to reconsider the Taggart decision, section 514(b)(6)(C) makes it clear *that welfare plans which subscribe to or use MET's as a funding vehicle are subject (as ERISA plans) to the provisions of title I, including the preemption provisions (which preempt State law in connection with such plans).*

128 Cong. Rec. 30,357-58 (1982) (emphasis added).

In this case, therefore, even were the AGRA group insurance plan a MET (which it is *not*), the Weiner Station nonetheless would have established an ERISA plan by subscribing to the MET. *A fortiori,* the Weiner Station must have established an ERISA plan when it subscribed to an employer group association plan which is not a MET, but which is itself an ERISA plan.

C. This Court Should Grant Certiorari Because the Decision of the Court Below Threatens to Substantially Weaken ERISA and the Important Federal Interests Served by ERISA.

The State Appellate Court ignored established, undisputed federal precedent and relied upon mere instinct to conclude that the plan at issue was not an ERISA plan. The State Appellate Court assumed that a small business

owned by a sole proprietor would not be creating an ERISA plan by buying health insurance for two employees. However, the statute, the decisions of this Court and those of the lower federal courts establish that ERISA applies to *all* employers, whether large or small.

The State Appellate Court overlooked the fact that millions of American workers are employed by small business, and that Congress desired that they be covered by ERISA, just as are the workers in large businesses. The State Appellate Court also overlooked the fact that the plan at issue is sponsored by an association of small employers, most if not all of whom would be unable to obtain similar insurance individually at the same rates.

The State Appellate Court decision is extraordinary, and its scope is potentially far-reaching. By eliminating an entire class of businessses from coverage by ERISA, that decision would allow assertion of the state law punitive damage claims from which ERISA shields employee benefit plans. Moreover, acceptance of that decision threatens the important Congressional goal of avoiding conflicting or inconsistent state and local regulation of employee benefit plans. *Pilot Life,* 481 U.S. at 46.

We reiterate that the decision, astounding on its face, was reached by resolving, summarily on appeal and on "disputed" facts, an issue which has never been litigated: whether the plans at issue were ERISA plans.[9]

The State Appellate Court decision in this case is exactly the type of state judicial involvement which Congress intended to prevent when it enacted ERISA's broad preemption provision. This Court, in *Metropolitan Life,* held that ERISA's remedies totally displace those provided for in state tort law. Had this suit been brought in federal court, as ERISA requires, the litigation would have taken a vastly different course.

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[9]Resolution of factual issues genuinely in dispute is, of course, a matter for the trier of fact, and cannot be accomplished on summary judgment. *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248-49 (1986). For this reason alone the State Appellate Court's decision should be reversed.

First, extra-contractual damages, including punitive damages, cannot be recovered in an ERISA action. *Massachusetts Mutual Life Ins. Co. v. Russell,* 473 U.S. 134 (1985).[10]

Thus, had this case been tried in federal court under established ERISA law, extra-contractual damages of any type, including punitive damages and damages for intentional infliction of mental distress, could not have been awarded. Under Florida tort law, however, these damages are recoverable. Consequently, because this case was decided under state common law and not ERISA, BCBSM and BCBSF were found liable for $7,200,000 in extra-contractual damages.

Second, the award of attorneys' fees would also have been very different if this case had been brought in federal court under ERISA. Although this Court has never addressed this issue, numerous federal courts have set forth detailed guidelines governing when attorneys' fees should be granted in an ERISA case. *Gray v. New England Tel. & Tel. Co.,* 792 F.2d 251 (1st Cir. 1986); *McKnight v. Southern Life and Health Ins. Co.,* 758 F.2d 1566 (11th Cir. 1985); *Lawrence v. Westerhaus,* 749 F.2d 494 (8th Cir. 1984); *Marquardt v. North American Car Corp.,* 652 F.2d 715 (7th Cir. 1981); *Hummell v. S.E. Rykoff & Co.,* 634 F.2d 446 (9th Cir. 1980); *Iron Workers Local No. 272 v. Bowen,* 624 F.2d 1255 (5th Cir. 1980); *Eaves v. Penn,* 587 F.2d 453 (10th Cir. 1978); *Ford v. New York Cent. Teamsters Pension Fund,* 506 F. Supp. 180 (W.D.N.Y. 1980), *aff'd,* 642 F.2d 664 (2nd Cir. 1981). These Courts have held that in determining whether to award attorneys' fees, the factors to be considered are: (1) the

[10]Although the holding of this Court in *Massachusetts Mutual* was expressly limited to ERISA §1109, numerous Circuit Courts of Appeal have since held that it is properly extended to ERISA §1132 cases, such as the case at bar. *See Varhola v. Doe,* 820 F.2d 809 (6th Cir. 1987); *Kleinhans v. Lisle Savings Profit Sharing Trust,* 810 F.2d 618 (7th Cir. 1987); *Sokol v. Bernstein,* 803 F.2d 532 (9th Cir. 1986); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.,* 793 F.2d 1456 (5th Cir.), *reh'g denied,* 797 F.2d 977 (5th Cir. 1986), *cert. denied,* 479 U.S. 1034, *cert. denied,* 479 U.S. 1089 (1987); *Powell v. C&P Telephone Co. of Va.,* 780 F.2d 419 (4th Cir. 1985), *cert. denied,* 476 U.S. 1170 (1986).

degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions.

These guidelines for the award of attorneys' fees in ERISA cases were not considered by the State Appellate Court in determining whether to award attorneys fees in this case. Rather, the award of attorneys' fees was based on a provision of the Florida Statutes permitting the award of attorneys' fees in controversies over the coverage of insurance policies. Thus, the initial decision whether to award attorneys fees *at all* would have been different had the case been brought in federal court under ERISA.

Moreover, the *amount* of attorneys' fees awarded under ERISA would have been different than the amount awarded by the State Appellate Court. The Third Circuit has stated that Congress did not intend the award of attorneys' fees for private enforcement of ERISA to be used as a means to inflict punishment. *Ursic v. Bethlehem Mines,* 719 F.2d 670 (3d Cir. 1983).[11]

Finally, while tort actions in Florida may be tried to a jury, the vast majority of the federal courts which have addressed the issue have held that jury trials are not

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[11]In a myriad of federal attorneys' fees cases, including this Court's decisions in *Blum v. Stenson,* 465 U.S. 886 (1984), and *Hensley v. Eckerhart,* 461 U.S. 424 (1983), the federal courts have established a well-structured procedure for the granting of reasonable attorneys' fees under federal law. The State Appellate Court found that a multiplier of three should be used for a substantial portion of the total lodestar. The use of this multiplier produced an attorneys' fees award that is far from reasonable. It is inconceivable that any federal court would have awarded three times the lodestar. Therefore, if this case had been litigated in the federal court, under ERISA, any award of attorneys' fees would have been considerably smaller, even assuming that the Weiners would have won.

permitted under ERISA.[12]

The danger posed by the decision under challenge here was recognized by Congress. Congress was concerned with the costs entailed by employee benefit plans, and sought to insure that ERISA would *encourage* the establishment of such plans. As stated by Representative Collier:

> [ERISA] should not be implemented in a way which will force employers to end their plans or perhaps discourage other employers from beginning them.

120 Cong. Rec. 29,209 (1974). Senator Williams expressed this concern explicitly:

> We have been told that [ERISA] will greatly increase the costs of private pension plans, something I am sure none of the Senators would like to see occur. This is particularly true if these increased pension costs result in the termination of private pension plans. Certainly this is not the intent of this legislation which is designed to improve and encourage the expansion of private pension plans.

120 Cong. Rec. 29,928 (1974). Congress' fear, articulated above, could become a reality if the State Appellate Court decision is permitted to stand. The decision surely will encourage the ruinous litigation and exorbitant insurance costs which will prevent businesses (especially small businesses) from adopting employee benefit plans.

This Court in *Pilot Life* explained the "careful balancing" represented by the civil enforcement scheme of §502(a) of ERISA, 29 U.S.C. §1132(a):

> In sum, the detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that

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[12] *See Cox v. Keystone Carbon Co.*, 861 F.2d 390 (3d Cir. 1988); *Chilton v. Savannah Foods & Indus., Inc.*, 814 F.2d 620 (11th Cir. 1987); *Howard v. Parisian, Inc.*, 807 F.2d 1560 (11th Cir. 1987); *Turner v. CF&I Steel Corp.*, 770 F.2d 43 (3d Cir. 1985), *cert. denied*, 474 U.S. 1058 (1986); *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003 (4th Cir. 1985); *Katsaros v. Cody*, 744 F.2d 270 (2nd Cir.), *cert. denied*, 469 U.S. 1072 (1984); *In re Vorpahl*, 695 F.2d 318 (8th Cir. 1982); *Calamia v. Spivey*, 632 F.2d 1235 (5th Cir. 1980).

> represents a *careful balancing* of the need for prompt and fair claims settlement procedures against the *public interest in encouraging the formation of employee benefit plans . . . . [T]he federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.*

481 U.S. at 54 (emphasis added). The judgment in this case makes a mockery of this statement. The goals established by Congress in ERISA cannot be achieved unless all courts — state and federal — understand the unique and extraordinary nature of ERISA preemption, comprehend the importance of federal court jurisdiction over ERISA issues, and appreciate exactly what an ERISA plan is — and is not. This Court must grant *certiorari* in this case in order to prevent further, dangerous misinterpretation of ERISA's provisions.

CONCLUSION

For all of the foregoing reasons, BCBSM respectfully requests that this Court, as the guardian of the federal rights so clearly expressed in ERISA, issue a Writ of Certiorari to review the decision rendered in this case.

Respectfully submitted,

Shale D. Stiller
Counsel of Record
Leonard E. Cohen
Allan P. Hillman
Frank, Bernstein, Conaway & Goldman
300 East Lombard Street
Baltimore, Maryland 21202
(301) 625-3500

Attorneys for Petitioner

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